Introduction

June 1, 2014:
Indiana implements eligibility changes to the aged, blind, and disabled (ABD) Medicaid program

Key Outcomes:

1) Comprehensive coverage for more Hoosiers
   - Maintain consistent eligibility
   - Ensure consistent provider reimbursement

2) Simplified disability eligibility process
   - Coordinated State and Federal disability determination

3) Efficient use of Hoosier taxpayer dollars
   - Leverage federal programs
   - Marketplace subsidies
   - Medicare Savings Program match
Introduction

• This presentation addresses:
  – Upcoming ABD Medicaid program changes & improvements
  – Transition plan for current members
  – Future Medicaid application process changes
Background & Program Changes

Program Changes & Improvements

Transition Plan

Application Process Changes
**209(b) and 1634: What Does It Mean?**

- Federal government allows states options for determining Medicaid eligibility for the aged, blind & disabled population
- Indiana is currently a 209(b) State
- In 2013, the Indiana General Assembly passed legislation to transition the State to 1634 status (IC 12-15-2-3.5)

<table>
<thead>
<tr>
<th>Policy Difference</th>
<th>Current Status: 209 (b)</th>
<th>Future Status: (1634)</th>
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</thead>
<tbody>
<tr>
<td>SSI (Supplemental Security Income) Recipients &amp; Medicaid Enrollment</td>
<td>• No automatic enrollment&lt;br&gt; • Separate application to Medicaid required</td>
<td>• Automatic enrollment&lt;br&gt; • No separate application</td>
</tr>
<tr>
<td>Spend Down Program</td>
<td>• State is required to operate a spend down program.</td>
<td>• State is not required to operate a spend down program</td>
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Spend Down Basics

Individuals with income over the SSI limit qualify if they meet other eligibility requirements

- Member spends down amount of excess income on medical bills

When spend down amount is met:

- Any remaining medical bills that month paid by Medicaid
- Process repeats each month
- Problems with spend-down:
  - Member coverage gaps
  - Inconsistent provider reimbursement

Spend down used by all aged, blind, & disabled populations over the SSI limit

- Duals (Medicare eligible)
- Non-Duals (non-Medicare eligible)
- Individuals with severe mental illness (SMI)
- Institutionalized and waiver services recipients > 300% Federal Benefit Rate
Eligibility Impact

- 76,010 members use the spend down provision
- Family and Social Services Administration assessed impact of eliminating spend down
  - As a 1634 state, Indiana is no longer required to operate the program
- Eligibility changes will be implemented to minimize loss of coverage & services
Eligibility Changes

- **Increase** full coverage income eligibility limit to 100% FPL
- **Expand** income eligibility for the Medicare Savings Program
- **Create** new 1915(i) Behavioral and Primary Healthcare Coordination (BPHC) program
  - Medicaid Rehabilitation Option (MRO) services for members with Serious Mental Illness (SMI)
Transition Plan for Current Members

Program Changes & Improvements

Transition Plan

Application Process Changes
Future Coverage Opportunities for Current Members

Medicare Status-
(Dual/Non-Dual)*

Need for MRO Services

Income

Use of Institutional or Waiver Services

*Dual = Medicare & Medicaid coverage
Non-Dual = Medicaid coverage only
Non-Duals (no Medicare) with Spend Down: Future Coverage

**Full ABD Medicaid**

Current eligibility: $721/month (individual)

- Future eligibility: 100% FPL ($973/month-individual)
- 2,882 new members

**Marketplace Coverage**

Qualified Health Plans (QHPs)

- Non-duals between 100% and 400% FPL will qualify for:
  - Premium Tax Credits
  - Cost-Sharing Reductions
- 7,486 members transition to Marketplace
Duals (Medicare-eligible) with Spend Down: Future Coverage

**Full ABD Medicaid**
- Current Eligibility: $721/month (individual)
- Future eligibility: 100% FPL ($973/month-individual)
- 23,860 new members

**Medicare Savings Program: Premium & Cost-Sharing Support**
- Current Eligibility: 100% FPL
- Future eligibility: 150% FPL
- Benefits: Payment of Parts A & B premiums, deductibles, & cost-sharing
- 26,879 new members

**Medicare Savings Program: Premium Support**
- Current Eligibility: 135% FPL
- Future eligibility: 185% FPL
- Benefits: Payment of Part B premiums
- 6,906 new members
Spend Down vs. Marketplace: Costs & Services

- QHPs & Medicaid have similar services coverage
  - Some service limits for physical therapy, home health, & chiropractic
  - Non-emergency transportation & adult dental not covered
    - Dental coverage can be purchased separately
    - Low overall expenditures on transportation & dental in SFY 2013
- Marketplace coverage may be less expensive than spend down for members <400% FPL
# Spend Down vs. Marketplace: Cost Data

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<tr>
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<tbody>
<tr>
<td>100% - 133%</td>
<td>$11,491-$15,281</td>
<td>2%</td>
<td>$19 - $25</td>
<td>$236-$556</td>
<td>$2,250</td>
<td>$354-$4,122</td>
</tr>
<tr>
<td>133% - 150%</td>
<td>$15,282-$17,235</td>
<td>3%</td>
<td>$38 - $43</td>
<td>$557-$722</td>
<td>$2,250</td>
<td>$3,978-$5,898</td>
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<tr>
<td>150% - 200%</td>
<td>$17,235-$22,980</td>
<td>4%-6.3%</td>
<td>$57 - $120</td>
<td>$723-$1,208</td>
<td>$5,200</td>
<td>$2,792-$7,856</td>
</tr>
<tr>
<td>200%-250%</td>
<td>$22,981-$28,725</td>
<td>6.3%-8.05%</td>
<td>$121-$192</td>
<td>$1,209-$1,694</td>
<td>$6,350</td>
<td>$6,706-$11,674</td>
</tr>
<tr>
<td>250% -300%</td>
<td>$28,726-$34,470</td>
<td>8.05%-9.5%</td>
<td>$193-$272</td>
<td>$1,695-$2,181</td>
<td>$6,350</td>
<td>$11,674-$16,558</td>
</tr>
<tr>
<td>300%-400%</td>
<td>$34,471-$45,460</td>
<td>9.5%</td>
<td>$273-$325</td>
<td>$2,182-$3,153</td>
<td>$6,350</td>
<td>$16,558-$27,586</td>
</tr>
</tbody>
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* Spend down estimate based on difference between federal benefit rate and estimated monthly income at specified FPL

** Out of pocket maximum may be less, actual out of pocket maximum dependent selected plan
Future Coverage for Members with SMI

- Medicaid Rehabilitation Option (MRO) services not covered by:
  - Medicare
  - Most QHP’s

- New 1915(i) program will provide continued MRO access

- Behavioral and Primary Healthcare Coordination (BPHC) program services:
  - Coordination of healthcare services across systems
  - Assistance in navigating the healthcare system
  - Referral and linkages to providers
## Proposed 1915(i) Eligibility Criteria

### Targeting Criteria
- Age 19 +
- Medicaid Rehabilitation Option (MRO) eligible primary mental health diagnosis
  - (ex: schizophrenia, bipolar disorder, major depressive disorder, psychotic disorder)

### Needs-Based Criteria
- Demonstrated need related to management of behavioral & physical health
- Demonstrated impairment in self-management of physical and behavioral health services
- ANSA LON 3+*
- Demonstrated health need which requires assistance and support in coordinating behavioral health & physical health treatment

### Financial Eligibility
- Income below 300% of the federal poverty level (FPL)

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Limit**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$2,919</td>
</tr>
<tr>
<td>Married</td>
<td>$3,993</td>
</tr>
</tbody>
</table>

*Refers to a score on the Adult Needs and Strength Assessment (ANSA), a behavioral health screening tool

**There are certain income disregards that may be applied to lower countable income. If there are children or other qualifying dependents in the individual’s household, an individual’s income may be higher than those listed in the table. A $361 per qualifying individual deduction may be applied.
Future Coverage for Institutionalized and Waiver Members

- Institutionalized and waiver spend down members able to keep coverage
  - If member income is at or below threshold:
    - No change or member action required
- If member income exceeds threshold:
  - Member must establish a Miller trust
    - Without Miller trust, member loses eligibility

<table>
<thead>
<tr>
<th>Monthly Income Limit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,163</td>
</tr>
</tbody>
</table>

- Monthly income limit = 300% of the maximum Federal SSA Benefit Rate.
  - Also known as the SIL: Special Income Limit
Miller Trust Background

- A Miller Trust is a legal structure that allows income in excess of the eligibility limit for institutional and waiver services to be disregarded.

How a Miller Trust Works

Member establishes Miller Trust → Member deposits income in excess of SIL into the trust monthly → Post-eligibility deductions applied

Trustee pays remaining funds to institution or providers → Medicaid pays remaining cost of services for the month → Process repeats monthly

Upon member’s death, all funds in the trust paid to Medicaid
How Does a Member Establish a Miller Trust?

- Establish a valid legal document that complies with requirements
- Establish a trust account at a financial institution
- Deposit income that exceeds SIL to the trust each month

**Resources being developed:**
- Miller trust instructions & template
- Referral list for free or low-cost legal assistance:
  - Local Area Agencies on Aging
  - Local elder law attorneys
  - Legal Aid
  - Indiana Legal services

**3,423 members over the SIL (December 2013):**
- 3,197 institutionalized members
- 226 waiver members
- Some may already have Miller trusts
# Transition Plan Summary

<table>
<thead>
<tr>
<th>Impacted Group</th>
<th>Transition Plan</th>
<th>Member Action Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI Recipients not enrolled in Medicaid</td>
<td>State enrolls in full ABD Medicaid</td>
<td>None Notice will be sent by State</td>
</tr>
<tr>
<td>Individuals  &lt;=100% FPL not enrolled in full Medicaid*</td>
<td>State enrolls in full ABD Medicaid</td>
<td>None Notice will be sent by State</td>
</tr>
<tr>
<td>Duals 100%-185% FPL*</td>
<td>State enrolls in Medicare Savings Program</td>
<td>None Notice will be sent by State</td>
</tr>
<tr>
<td>Duals &gt;185% FPL</td>
<td>Refer to State Health Insurance Assistance Program (SHIP)</td>
<td>Contact SHIP to learn about supplemental coverage options</td>
</tr>
<tr>
<td>Non-duals &gt;100% FPL</td>
<td>Refer to Marketplace</td>
<td>Enroll in Marketplace coverage &amp; affordability programs</td>
</tr>
</tbody>
</table>

*Only those enrolled in spend down or a Medicare Savings Program will be automatically transitioned; new members will have to apply for coverage*
## Transition Plan Summary, cont.

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<thead>
<tr>
<th>Impacted Group</th>
<th>Transition Plan</th>
<th>Member Action Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals with SMI &gt;100% FPL</td>
<td>1915(i) BPHC program for coverage of MRO services</td>
<td>Apply through Community Mental Health Center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Providers notified of changes and will assist</td>
</tr>
<tr>
<td>Institutional and Waiver Beneficiaries &lt;Special Income Limit</td>
<td>No changes in coverage</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Notice will be sent by State</td>
</tr>
<tr>
<td>Institutional and Waiver Beneficiaries &gt;Special Income Limit</td>
<td>Communication, outreach, &amp; resources</td>
<td>Establish Miller trust before June 1, 2014 to maintain eligibility</td>
</tr>
<tr>
<td></td>
<td>• Establish Miller trust to maintain eligibility</td>
<td></td>
</tr>
</tbody>
</table>
Member & Provider Communications

Member Notices

- General:
  - 1634 late February
- Specific (1915(i), early February; 1634, early April):
  - Recommended action (if any)
  - Instructions for reporting changes in circumstances
- Final (mid-May):
  - Notification of appeal rights
  - Notification of new status/disenrollment

Web Resource Center

- [http://www.fssa.IN.gov](http://www.fssa.IN.gov) under “Resources”
- Member Frequently Asked Questions (FAQ’s)
- Eligibility screening guide
- Instructions & template for establishing Miller trust

Provider Bulletin and FAQ’s

- Issued mid-April

*All dates are estimated.*
Current Members & SSA Disability Determinations

• Current members auto-transitioned without regard to status with SSA

• When due for an Medical Review Team (MRT) progress report:
  – State will require member to apply to SSA for disability determination
  – Current members may initiate SSA application process before next scheduled progress report
Process Changes for Future Applicants

How the ABD Medicaid application process will change in Indiana post-transition
Disability Medicaid Application Process Post-Transition

Application to SSA for Disability Benefits

Exceptions:
- Direct application to IN Medicaid without SSA determination if:
  - Applicant is a child
  - Applicant has a recognized religious objection to applying for federal benefits (e.g., Amish)

**SSI Eligible**
- State auto-enrolls in Medicaid

**SSDI-Eligible**
- Apply to Indiana Medicaid for verification of other eligibility factors
- Will not undergo MRT process

**SSA Denial** (determined non-disabled)
- Generally Medicaid ineligible
  - State will not initiate MRT process for applicant except in two cases (to be discussed)
Medicaid Applications without SSA Disability Determination

State will require SSA application for disability determination

SSA application status checked through SDX file

If no SSA application filed within 45 days from Medicaid application date:
  • Medicaid application denied

State will initiate MRT process

If SSA determination received during MRT process:
  • State stops MRT
  • State defers to SSA decision

MRT determination applies pending SSA decision

If the two conflict:
  • SSA overrides MRT
Exceptions to SSA Denial

Applicant with an SSA denial may undergo MRT process in the following circumstances:

• Change or worsening of old condition since SSA denial OR
• A new condition, AND

1. More than 12 months have passed since denial
   • State will require applicant to re-apply/appeal to SSA

OR

2. Fewer than 12 months have passed since denial and SSA has refused to consider new evidence
Post-Transition Appeals

• Applicant should appeal to SSA if:
  – Applicant has an SSA disability denial

• Applicant should appeal to Indiana Medicaid if:
  – MRT determined applicant non-disabled
  – Application denied for reasons other than disability (i.e., excess income or resources)
Conclusion
Impacts of 1634 Transition and Associated Changes

- More comprehensive coverage for spend down members
  - Full Medicaid for members up to 100% FPL
  - Premium & cost-sharing support for Medicare recipients < 150% FPL
  - Premium support for Medicare recipients > 150% FPL
- Simplified eligibility processes
- Ability to cover more low income Hoosiers:
  - 14,000 current SSI recipients not currently enrolled in Indiana Medicaid
  - Future SSI recipients
  - About 28,000 Medicare recipients not enrolled in spend down or the Medicare Savings program
- Efficient use of Hoosier taxpayer dollars
  - $35.7 million savings in SFY 2015
  - Similar savings in future years
Member Transition Summary

- **Full ABD Medicaid**: 35%
  - 26,742 members
- **Medicare Savings Program: Premium & Cost-Sharing Support**: 35%
  - 26,879 members
- **Marketplace**: 10%
  - 7,486 members
- **May be eligible for supplemental Medicare coverage**: 11%
  - 7,997 members
- **Medicare Savings Program: Premium Support**: 9%
  - 6,906 members

Total spend down members: 76,010 as of December 2013.

*Some will also be eligible for the BPHC program.*
Transition Timeline

January 30
Stakeholder Meeting & 1634 Web Resource Center launch

Late February
1634 Initial Member Notice

Early April
Issue Provider Bulletin & FAQs

Early April
1634 2nd Member Notice

Mid-May
Final Member Notice

June 1:
Go Live

TECHNICAL IMPLEMENTATION & STAFF TRAINING

*All dates are estimated.
For More Information

• Visit the Web Resource Center:
  • [http://www.fssa.in.gov](http://www.fssa.in.gov)
  • Under “Resources”
  • [http://www.indianamedicaid.com](http://www.indianamedicaid.com) on the “Members” and Providers” pages